**FAMILY PLANNING PERIODIC ASSESSMENT**

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<th>Date: _______</th>
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**Reason for visit:**

**Current Contraceptive Method:**

**Interim History/Problems:**

**Assessment/Evaluation of Recipient:**

- Chest Pain: __________________________________
- Abdominal Pain: _______________________________
- Headaches: ___________________________________
- Leg Pain: ____________________________________
- Excessive Bleeding: ___________________________
- Vaginal Discharge: ____________________________

**Pelvic exam (if indicated):** __________________________

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**MUST COMPLETE ONE OF THE TWO COUNSELING SECTIONS BELOW (check the applicable box)**

- □ Counseling using PT+3 Teaching Method
- □ Alternative Family Planning Counseling  
  *(check each step as completed):*
  - □ Reproductive A&P (if indicated)
  - □ Contraceptive methods
  - □ Effectiveness of chosen method
  - □ Side effects/dangers
  - □ How to use chosen method
  - □ Contraceptive Fact Sheet given
  - □ Phone # given for problem/emergency

**Contraceptive Method:**

- Supplies issued: □ Yes □ No
- Type of supplies: ______________________________
- Prescription issues: □ Yes □ No
- Name of Prescriptions: _________________________
- Next Appointment Date: _________________________

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**Comments:**

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

**Signature** _____________________________________  **Date** ____________________________

**Signature** _____________________________________  **Date** ____________________________